

BOARD OF COMMUNITY HEALTH
July 13, 2006

The Board of Community Health held its regularly scheduled meeting in the Community Room, Appalachian Community Bank, 150 Orvin Lance Connector, Blue Ridge, Georgia. Board members attending were Jeff Anderson, Chairman; Richard Holmes, Vice Chairman; Mark Oshnock, Secretary; Mary Covington (via phone); and Ross Mason. Commissioner Rhonda Medows was also present. (A List of Attendees and Agenda are attached hereto and made official parts of these Minutes as Attachments # 1 and # 2).

Mr. Anderson called the meeting to order at 12:09 p.m. The Minutes of the June 8, 2006 meeting were UNANIMOUSLY APPROVED AND ADOPTED. He thanked Mr. Neil Pruitt of UHS Pruitt Corporation and the Appalachian Community Bank for hosting the board meeting. Mr. Anderson also recognized and welcomed Representative John Meadows, District 5.

Mr. Anderson called on Dr. Medows for the Commissioner's Report. Dr. Medows stated that she would delay her comments and instead allow Mr. Mark Trail, Chief, Medical Assistance Plans, to address therapy issues particularly in Fee For Service (FFS) Medicaid. Mr. Trail began discussion on upcoming policy changes in the Children's Intervention Services (CIS) program. He said this program offers certain specialized services to children—EPSDT-related services provided as a unique requirement of the Medicaid program. The Department is proposing, which was included in both the Department's and Governor's recommendations and included in the final budget, to engage with Administrative Service Organizations (ASO) types to include certain care management functions. Added in the legislation language was to make it a "gatekeeper model" as well. As the Department approaches addressing this directive, it has worked to properly segment the work in such a way that existing resources may be utilized, and where it needed to engage more or new resources it would go about doing that particularly focusing on the CIS program.

Mr. Trail stated that one of the current gate keeping functions already in place is for the therapists (in this case) to present certain documents to demonstrate medical necessity once they have passed a certain threshold each month in providing services. Currently that threshold is set at 20 units per month. Depending on the discipline, a unit is measured in different ways. Most all speech units are considered to be an episode or a particular visit; most of the physical therapy and occupational visits are time units—15-minute segments. Presently the policy requires any therapy in a particular month that exceeds 20 units would require prospective medical review or prior authorization. When conducting its research, the Department reviewed what other health plans do in regards to managing these types of services and also looked at the management of these services within the three Care Management Organizations engaged to serve the Medicaid population.

Mr. Trail said the Department sought to make its policy more consistent with those various plans. As a result and through numerous discussions with stakeholder groups, the Department decided to modify its policy for the threshold from 20 to 8 units per month. The rest of the policy remains the same; what is required to seek prior authorization is the same; the documentation is the same. Another caveat is when there is more than one therapy discipline being provided prior authorization would be required anytime therapies exceed 16 units per month.

Mr. Trail shared with the board members a comparison of various health plans to reflect the Medicaid research that included the Medicaid current plan and what is being proposed, the State Health Benefit Plan, Tricare and the three CMOs.

Mr. Anderson asked what were the potential savings for the gatekeeper model. Mr. Trail said the total funds were approximately \$60+ million. This figure was derived by Mercer actuaries. He said there are a number of activities the Department will be changing such as precertification for children's in patient admissions and requiring medical review of certain outpatient therapies.

Dr. Medows asked Mr. Trail to describe the process when a child uses up the 8 units when prior authorization kicks in. Mr. Trail said the current process is a therapist does not have to use up the units before they apply for prior authorization; the same will occur in the future. The policy would become effective September 1, and the Department anticipates accepting prior authorizations beginning August 1 for September. Prior authorizations can be approved for up to three calendar months, and if therapists anticipate the care plan for a particular child would exceed the number of units they could apply ahead of time. The process is to start the

application for prior authorization over the web. There are a few documents that need to be faxed and attached to the application such as the care plan and a letter of medical necessity from the physician. The contractor has been turning the prior authorizations around in less than ten days. The Georgia Medical Care Foundation has also agreed to enter a date for prior authorization prospectively.

Mr. Anderson called on Charemon Grant to give the General Counsel's update. Ms. Grant presented to the Board for initial adoption changes to Chapter 111-4-1-.02 and Chapter 111-4-1-.07. The proposed amendments reflect the State Health Benefit Plan's (SHBP) current business operations and additional changes to reflect the passage of HB 1372. Ms. Grant gave an explanation of changes.

- Section 111-4-1-.02 (1)(c) (1) subscribers may be assessed a tobacco surcharge in amount approved by the board. If there is a determination that the subscriber or his covered dependents have used tobacco products in previous 12-month period, the surcharge shall be added to the subscriber's premium for the remainder of the plan year unless the tobacco user can demonstrate that they participated in a smoking cessation program.
- Section 111-4-1-.02 (1)(c)(2) has been added to reflect that a subscriber may be subject to a spousal surcharge in an amount approved by the Board if the subscriber elects to cover his or her spouse under the SHBP although they may have been able to get coverage under the spouse's plan. The surcharge will not be assessed if the spouse is already eligible for coverage under the SHBP and they indicate as such during Open Enrollment.
- Under 111-4-1-.02(d)(4) the reference to 18 hours has been stricken and replaced with seventeen and a half (17 ½) hours to be compliant with statutory requirements.
- 111-4-1-.02(e)(3) has been modified to reflect the various agencies with whom the DCH Board may contract for the inclusion of employees, retired employees and dependents in the SHBP.
- A new subsection, 111-4-1-.02(e)(4), has been added to reflect that the Board may contract with any qualified Consumer Driven Health Plan (CDHP) licensed to do business in Georgia.
- Subsection 111-4-1-.02(1)(e)(5)(i) has been added to reflect passage of HB 1372 which gives the Commissioner the right upon written notice to terminate coverage of groups that have contracted with the SHBP but have failed to remit the employer or employee contribution.
- In addition, a section has been added to reflect that if the group makes the required contribution they may be reinstated.
- Lastly, under subsection 111-4-1-.02(1)(e)(5)(iii) the board may require specified groups to provide a bond to ensure payment performance.

Ms. Grant continued with an explanation of changes to 111-4-1-.07 which modifies existing regulations to reflect passage of HB 1372. This section has been added to provide that the SHBP will provide a coverage exception to a correctional officer if that officer has been injured within a time period of five (5) years or less from becoming eligible for Medicare. If that is the case they will be excepted from the eight-year or more employment requirement and will be eligible for coverage which will extended to their spouses or eligible dependents. Ms. Grant concluded her review after addressing questions from the Board. Mr. Mason MADE a MOTION to approve Rules 111-4-1-.02 and .07 for initial adoption to be published for public comment. Mr. Oshnock SECONDED the MOTION. Mr. Anderson called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (Copies of Rules 111-4-1-.02 and .07 have been attached hereto and made official parts of these Minutes as Attachments # 3 and 4).

Mr. Anderson called on Mark Trail, Chief, Medical Assistance Plans, to present the Dental Services Public Notice. Mr. Trail stated that at the June 8 board meeting, the board released a public notice to add some limited preventive and restorative benefits to pregnant women in the Medicaid Program. He said the Department had been working with the Georgia Dental Association and the Georgia Dental Society on specific codes to implement the policy. Ms. Covington MADE a MOTION to approve the Dental Services Public Notice. Mr. Holmes SECONDED the MOTION. Mr. Anderson called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (A copy of the Dental Services Public Notice is attached hereto and made an official part of the minutes as Attachment # 5).

Mr. Anderson recognized and welcomed Representative Charles Jenkins, District 8.

Mr. Anderson called on Carie Summers to give the Chief Financial Officer's report. Ms. Summers began review on the Physician Upper Payment Limit Payments Public Notice that the Board approved at the June board meeting to be published for public comment. She said the board approved last fall the creation of an Upper Payment Limit Program for physicians specifically for physicians affiliated with both a medical school as well as a public teaching facility. This public notice will expand this program effective with dates of service on or after August 1, 2006. The expansion of the program would allow the Department to make supplemental payments for services that are provided outside a hospital setting and limit the participation in the program to teaching facilities located in Metropolitan Statistical Areas. This expansion is anticipated to cost \$4.8 million in total funds on an annual basis. The state matching share is \$1.9 million and the source of the state matching funds is either Intergovernmental Transfers provided by the public teaching facilities, state appropriations made available by the Georgia Board for Physician Workforce, or future state appropriations specifically designated as a source of matching funds for physician UPL. Mr. Holmes MADE a MOTION to approve the Upper Payment Limit Payments Public Notice. Mr. Mason SECONDED the MOTION. Mr. Anderson called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (A copy of the Upper Payment Limit Payments Public Notice is attached hereto and made an official part of the minutes as Attachment # 6).

Next, Ms. Summers gave an update on other Upper Payment Limit programs—In Patient Hospital, Out Patient Hospital and Nursing Home. She said on the Nursing Home UPL program, the department made payments on June 2 in the amount of \$94 million to participating non-state governmental nursing homes. That program is financed with intergovernmental transfers from those facilities and after consideration of the IGT amount, those facilities netted \$62 million from that transaction. On the Out Patient UPL program the department received approval from the Centers for Medicare and Medicaid Services (CMS) this week for FY 06 UPL payments. On July 21, the department expects to make payments of \$68.5 million and since those are primarily IGT sponsored and some state dollars for Critical Access Hospitals, hospitals would net about \$43.7 million in federal funds. The Department has not received approval from CMS on the In Patient UPL program. If CMS approves what the Department has submitted, DCH would expect In Patient UPL payments for FY 06 to be about \$117.9 million of which hospitals would net about \$71 million. Hospitals that would benefit from the payments include governmental and Critical Access Hospitals. The Department expects both hospital programs would net about \$115 million—a \$25 million increase from last year.

Ms. Summers said the department is awaiting approval from CMS on the Disproportionate Share Hospital (DSH) program State Plan Amendment. The Department received authorization to make 50% interim payments. The Department has about \$208 million that has to be paid out once it receives State Plan Amendment approval from CMS. Ms. Summers said she is hopeful the Department will receive approval concurrently with In Patient UPL State Plan Approval to proceed with DSH payments since both have to be considered to make calculations. Mr. Anderson asked Ms. Summers and Dr. Medows to draft a letter for the Governor's signature to ask why it has taken so long and what can the Department do to improve the process to get payments faster. Ms. Summers said that as a reminder, the Department would not be in this position again in FY 07 in needing a State Plan Approval. There is however, one particular change that will occur in the FY 07 calculations--the Department will have to share and seek approval from CMS regarding the impact of managed care on UPL calculations and how DCH actually accounts for that as required by federal law. Dr. Medows said that a personal visit to CMS in Washington may be helpful to improve the process and open dialogue with CMS.

Ms. Summers added that the Board had approved a rate increase for nursing homes with an effective date of service of July 1, 2006. CMS has approved the State Plan Amendment that will update the cost reports used for July 1 effective dates of service for nursing home services. Mr. Anderson asked Ms. Summers if budget planning would begin in August. Ms. Summers said yes and concluded her updates. Mr. Anderson asked the board for any new business. There was none and Mr. Anderson opened the meeting for public comment.

Public comment regarding therapy visits was given by Donna Davidson, TriAlliance; Janet Hendrix, Associated Therapies; John Camp, parent; Althea Montgomery, Child

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Development Project; Sandi Marcus, Autism in Bartow; Tammie Kimball, parent; and Barbara Pagillo, private pediatric therapist.

There being no further business to be brought before the Board at the meeting Mr. Anderson adjourned the meeting at 1:34 p.m.

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED THIS THE _____ DAY OF _____, 2006.

JEFF ANDERSON
Chairman

ATTEST TO:

MARK D. OSHNOCK
Secretary

Official Attachments:

- #1 List of attendees
- #2 Agenda
- #3 Rules 111-1-4-1-.02
- #4 Rules 111-1-4-1-.07
- #5 Dental Services Public Notice
- #6 Upper Payment Limit Payments Public Notice